DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 9 — 0 0 9

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
4-1-99

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 99 $ 31,169
b. FFY 00 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages
2,3,5,6,7,7a, ,9a,10,13,13a,18,19, & 20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages
2,3,5,6,7,7a, 9a,10,12,13,13a13b,18,19,20,
21, 22, 23

10. SUBJECT OF AMENDMENT:
Adds the trend factor for State Fiscal Year 99, adjusts per diem rates revised when outlier payments are made, ~~by~~ and adds growth factors to uninsured costs.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT JP
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
for

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director

15. DATE SUBMITTED:
June 29, 1999

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
06/30/99

18. DATE APPROVED:
AUG 28 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04/01/99

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting
ARA for Medicaid and State Operations

23. REMARKS:
cc:
Martin
Vadner
Waite

SPA CONTROL
Date Submitted 06/29/99
Date Received 06/30/99

FORM HCFA-179 (07-92)

Instructions on Back

3. Disproportionate share reimbursement - The disproportionate share payments described in sections XVI and XVIII.B include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection VI.A.1 and 2 and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation are described in sections XVI, and XVIII.B. These Safety Net and Uninsured Add-Ons are subject to federal limitation described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section VI.E.

II. Definitions.

A. Allowable costs. Allowable costs are those related to covered Medicaid services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the Missouri Medicaid hospital provider manual and detailed on the desk reviewed Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

B. Bad debt - Bad debts should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures buts limits coverage. In addition, bad debts should not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

C. Base cost report--Desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during the calendar year. (For example, a provider has a cost report for the nine (9) months ending 9/30/94 and a cost report for the three (3) months ending 12/31/94.) If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

D. Charity Care - results from a providers policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

E. Contractual allowances--Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

F. Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

G. Disproportionate Share Reimbursement. The disproportionate share payments described in sections XVI and XVIII.B include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection V.A.1 and 2 and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation are described in sections XVI, and XVIII.B., of this regulation. These Safety Net and Uninsured Payments Add-Ons are subject to federal limitation as described in the Omnibus Reconciliation Act of 1993 (OBRA 93) and subsection VI.E.

H. Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification of the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

I. Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost Reports.

J. Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.

K. Per Diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section III.

$$\text{PER DIEM} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC-The operating component is the hospital's TAC less CMC;

2. CMC The capital and medical education component of the hospital's TAC;

3. MPD-Medicaid inpatient days;

4. MPDC-MPD as defined in III.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.;

5. TI-Trend Indices. The trend indices are applied to the OC of the per-diem rate. The trend indices for SFY 95 is used to adjust the OC to a common fiscal year end of June 30;

6. TAC-Allowable inpatient routine and special care unit expenses, ancillary expenses and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted by the TI.

8. The per diem shall be adjusted for rate increases granted in accordance with subsection V.F., for allowable costs not included in the base year cost report

B. Trend Indices (TI). Trend indices are determined based on the four (4) quarter average DRI Index for DRI-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill for SFY 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on the CPI Hospital index as published in Health Care Cost by DRI/McGraw-Hill for each SFY starting with SFY99.

1. The TI are-

   A. State Fiscal Year 1994-4.6%.,
   B. State Fiscal Year 1995-4.45%;
   C. State Fiscal Year 1996-4.575%;
   D. State Fiscal Year 1997-4.05%;
   E. State Fiscal Year 1998-3.1%;
   F. State Fiscal Year 1999-3.8%

2. The TI for SFY 96 through SFY 98 are applied as a full percentage to the OC of the per-diem rate and for SFY '99 the OC of June 30, 1998 rate shall be trended by 1.2%.

IV. Per-diem Rate New Hospitals.

A. Facilities Reimbursed by Medicare on a Per-Diem basis. In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's Medicaid rate may be one hundred twenty percent (120%) of the average-weighted, statewide per-diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Division of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

2. The termination of or by a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months after the close of the reporting period. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred. The payments due the hospital shall be withheld until the final cost report is filed with the Division of Medical Services.

3. All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the period prescribed in this subsection may result in the imposition of sanctions as described in 13 CSR 40-3.030.

4. Amended cost reports or other supplemental. The division will notify hospital by letter when the desk review of its cost report is completed. Since, this data may be used in the calculation of per-diem rates, direct payments, trended costs or uninsured add-on payments, the hospital shall review the desk review data and the schedule of key data elements and submit amended or corrected data to the division within fifteen (15) days. Data received after the fifteen (15)-day deadline will not be considered by the division for per-diem rates, direct payments trended costs or uninsured payments unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen (15)-day deadline.

B. Records

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by Missouri Medicaid (excluding cross-over claims), respectively. All records must be available upon request to representatives, employees, or contractors of the Missouri Medical Assistance Program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

   (a) A separate Medicaid log for each fiscal year must be maintained by either date of service or date of payment by Medicaid for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the Medicaid log should be used to complete the Medicaid worksheets in the hospital's cost report;

(b) Data required to be recorded in logs for each claim includes:

(1) Recipient name and Medicaid number;

(2) Dates of service;

(3) If inpatient claim, number of days paid for by Medicaid, classified by each subprovider, adults and pediatrics, newborn or specific type of intensive care;

(4) Charges for paid inpatient days and ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report.

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospitals fiscal year in accordance with Appendix B.

E. Adjustments to Rates

The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Medicaid agency from imposing any sanctions authorized by any statute or regulation;

2. When rate reconsideration is granted in accordance with subsection V.F.;

3. When the Medicare per-diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the Division of Medical services; and

F. Rate Reconsideration

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in paragraph I.A.3.III. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division of Medical Services' final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the Medicaid Agency:

   (a) Substantial changes in or costs due to case mix; or

   (b) New, expanded or terminated services as detailed in subsection V.C.

D. Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division's notification of the final determination of the rate.

E. OBRA 93 Limitation. In accordance with OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. The OBRA 93 Limitation shall be computed using the fourth prior year desk reviewed cost report trended thru the State Fiscal Year. If the sum of disproportionate share payments exceeds the estimated OBRA 93 limitation, the difference shall be deducted in order as necessary from safety net payment, other disproportionate share lump sum payments, direct Medicaid payments, and if necessary, as a reduced per diem.

VII.A. Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for Missouri Medicaid-eligible children under the age of six (6) will be made to hospitals, meeting the disproportionate share requirement in subsection VI.A., and for Missouri Medicaid-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met for the services to be eligible for outlier review:

   (a) the patient must be a Missouri Medicaid eligible infant under the age of one (1) year or for DSH a Missouri Medicaid-eligible child under the age of six (6) years for all dates of services presented for review;

   (b) Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age, must have qualified for disproportionate share status under section (6) of this plan for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph VII.A.5; and

   (C) one of the following conditions must be satisfied:

      (1) the total reimbursable charges for dates of service as described in subparagraph VII.A.1.(a) must be at least one hundred fifty percent (150%) of the sum of total third party liabilities and Medicaid inpatient claim payments for said claim; or

      (2) the dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days were reimbursed by Medicaid.

2. Claims for all dates of services eligible for outlier review must:

   (a) have been submitted to the Division of Medical Services' fiscal agent or the MC+ Health Plan in their entirety for routine claims processing and claims payments must have been made before the claims are submitted to the Division for outlier review; and

   (b) be submitted for outlier review with all documentation as required by the Division of Medical Services no later than ninety (90) days for the last payment made by the fiscal agent or the MC+ Health Plan through the normal claims processing system for those dates of services.

3. Claim charges and Medicaid payment data will be determined from claims data,

submitted to the Division of Medical Services fiscal agent by MC+ health plan or the hospital through normal claims processing.

4. The claims may be reviewed for:

   (a) medical necessity at an inpatient hospital level of care;

   (b) appropriateness of services provided in connection with the diagnosis; and

   (c) charges that are not permissible per the Division of Medical Services' policies established in the institutional manual and hospital bulletins.

5. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by June 1 of each year :

   (a) average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; and

   (b) ancillary cost to charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review.

   (c) no cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services, or return on equity.

6. Each State Fiscal Year outlier adjustment payments for each hospital will be made for all claims submitted before March 1 of the preceding SFY which satisfies all conditions in paragraph VII.A.l-4. The payments will be determined for each hospital as follows:

   (a) sum all reimbursable costs per paragraph VII.A.5. for all applicable outlier claims to equal total reimbursable costs.

   (b) subtract third party payments and Medicaid payments for said claims from total reimbursable costs to equal excess cost.

   (c) multiply excess costs by 50%.

B. Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for Missouri Medicaid recipients enrolled in MC+. All criteria listed under subsection VII.A. applies to MC+ outlier submissions.

XVII. In accordance with state and federal laws regarding reimbursement of unreimbursed Medicaid costs and the costs of services provided to uninsured patients, reimbursement for state fiscal year 1999 (July 1, 1999 - June 30, 2000) shall be determined as follows.

A. Medicaid Add-Ons for Shortfall

The Medicaid Add-On for the period of July, 1998 to December 31, 1998 will be based on fifty percent (50%) of the unreimbursed Medicaid costs as calculated for SFY 1998.

B. Uninsured Add-ons

The hospital shall receive ninety-nine percent (99%) of the Uninsured costs prorated over SFY 1999. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive one hundred percent (100%) of its uninsured costs prorated over SFY 1999. The uninsured Add-On will include:

1. The Add-On payment for the cost of the uninsured. This is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the uninsured is then trended to the current year using the trend indices in subsection III.B. and the growth factors listed in subsection XVIII.C.. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment; and

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk-reviewed cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days; and

4. The increased costs per day resulting from the utilization adjustment in subsection XV.B., is multiplied by the estimated uninsured days.

C. The Growth Factors. The growth factors applied to the uninsured costs for each SFY are:

1. SFY 1996-3.4%;
2. SFY 1997-3.4%
3. SFY 1998-3.3%; and
4. SFY 1999-3.3%.

XVIII. Medicaid GME Add-On -- A Medicaid Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a Medicaid managed care system such as MC+ in accordance with this section.

A. The Medicaid GME Add-On for Medicaid clients covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to Medicaid clients not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's Medicaid population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars ($100,000), 2) forty percent (40%) of their Medicaid days are related to Medicaid recipients eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars ($30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

XIX. Hospital Mergers. Hospitals that merge their operations under one Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.

A. The Disproportionate share status of the merged hospital provider shall be:

1. The same as the surviving hospital's status was prior to the merger for the remainder of the State Fiscal Year in which the merger occurred; and

2. Determined based on the combined desk reviewed data from the appropriate cost reports for the merged hospitals' in subsequent fiscal years.

B. The per diem rate for merged hospitals shall be calculated:

1. For the remainder of the State Fiscal Year in which the merger occurred by multiplying each hospital's estimated Medicaid paid days by its per diem rate, summing the estimated per diem payments and estimated Medicaid paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger; and

2. For subsequent State Fiscal Years based on the combined desk review data after taking into account the different fiscal years ends of the cost reports.

C. The Medicaid Direct Payment and uninsured shall be:

V 1. Combined under the surviving hospital's Medicaid provider number for the remainder of the State Fiscal Year in which the merger occurred; and

2. Calculated for subsequent State Fiscal Years based on the combined date from the appropriate cost report for each facility.

D. Merger of Children's Acute Care Hospital. When an acute care children's hospital merges with another acute care hospital, all the provisions in subsection XIX.A., shall apply, except the Medicaid provider number for the children's hospital will remain active for per diem and outpatient payments. The direct Medicaid payments and Uninsured Add-On payments will be made under the Medicaid number requested by the surviving hospital.